MICROBIOLOGY TEST REQUEST FORM

UNIFIED STATE LABORATORIES: PUBLIC HEALTH
4431 SOUTH 2700 WEST
TAYLORSVILLE, UTAH 84129
TELEPHONE: (801) 965-2400, (801) 965-2561
FAX: (801) 965-2551
http://health.utah.gov/lab/microbiology

FOR USLPH USE ONLY
LAB#

DATE STAMP

TESTING WILL NOT BE PERFORMED UNLESS FORM IS COMPLETELY FILLED OUT. PLEASE PRINT CLEARLY FOR ACCURACY.

PATIENT INFORMATION:

SAMPLE STATE OF ORIGIN:	UTAH PATIENT/SAMPLE COUNTY OF ORIGIN:	ZIP CODE:	DATE OF BIRTH (mm/dd/yyyy) _____/_____/_____	AGE	SEX M F

PATIENT NAME (Last, First):

PATIENT ID #

ETHNICITY
[ ] Hispanic
[ ] Non-Hispanic

RACE
[ ] White [ ] Black or African American [ ] American Indian or Alaska Native
[ ] Asian [ ] Native Hawaiian or other Pacific Islander

PROVIDER INFORMATION
Provider Code:
Physician: _____
Provider Phone: _____
Provider Email: _____
Secure Fax #: _____

SPECIMEN COLLECTION DATE AND TIME
(mm/dd/yy) _____/_____/_____
Time: _____

SPECIMEN SOURCE/SITE (CHOOSE 1):

[ ] Blood
[ ] Bronchoalveolar lavage
[ ] Bronchial aspirate
[ ] Bronchial wash
[ ] Cerebrospinal Fluid
[ ] Cervix
[ ] Endotracheal aspirate
[ ] Endotracheal wash
[ ] Environmental (specify):_____
[ ] Fluid (specify):_____
[ ] Food (specify):_____
[ ] Isolate (source):_____
[ ] Lesion (site):_____
[ ] Nasal (aspirate /swab / wash)
[ ] Nasopharyngeal swab
[ ] Nasopharyngeal-throat swab
[ ] Plasma
[ ] Rectum
[ ] Scab
[ ] Serum
[ ] Skin
[ ] Sputum (natural / induced)
[ ] Swab (specify site):_____
[ ] Stool
[ ] Throat swab
[ ] Tissue (specify):_____
[ ] Tracheal aspirate
[ ] Urethra
[ ] Urine
[ ] Vagina
[ ] Vomitus
[ ] Wound/Abcess
[ ] Other (specify): _____

BACTERIOLOGY/TUBERCULOSIS TESTS

[ ] Bacterial Culture
[ ] Bacterial ID / Referral
Presumptive ID:_____
[ ] *Mycobacterial* culture
[ ] *Mycobacterial* referral
Presumptive ID:_____
[ ] Other (specify):_____

BIOTERRORISM TESTS
(Notify Lab before submitting)

[ ] *Bacillus anthracis*
[ ] *Brucella* spp.
[ ] *Brucella* spp. Microagglutination
[ ] *Burkholderia mallei/pseudomallei*
[ ] *Clostridium botulinum* culture & toxin
[ ] *Coxiella burnetii*
[ ] Francisella tularensis
[ ] *F. tularensis* microagglutination
[ ] Orthopox virus
[ ] Vaccinia virus
[ ] Varicella zoster virus
[ ] Variola virus
[ ] *Yersinia pestis*
[ ] *Yersinia pestis* hemagglutination

[ ] Other (specify): _____

IMMUNOLOGY / VIROLOGY TESTS

[ ] *Chlamydia* and *Gonorrhea* by NAAT
[ ] Symptomatic
[ ] Pregnancy test only visit
[ ] Positive CT in the past 12 months
[ ] Client meets screening criteria
[ ] New partner in the last 60 days
[ ] >1 partner in the last 60 days
[ ] Patient request
[ ] IUD insertion
[ ] Cervical friability
[ ] Mucopus
[ ] PID
[ ] Urethritis

[ ] Colorado tick fever
[ ] Cytomegalovirus
[ ] HBsAb (antibody)
[ ] HBsAg (antigen)
[ ] HCVAb (antibody)

[ ] HIV EIA
HIV specimen required information
[ ] Repeat testing of reactive
[ ] Rapid test Reactive confirmation

[ ] Hantavirus (Sin Nombre)
[ ] Herpes simplex virus with typing
[ ] Influenza A & B virus PCR
(with subtyping)
[ ] Hospitalized w/ Influenza-like illness
[ ] Sentinel site
[ ] Other (i.e., cluster investigation)
Cluster location: _____
Other reason for testing: _____

[ ] Measles
[ ] Mumps
[ ] QuantiFERON-TB Gold
QuantiFERON specimen required information
Incubation start time_____ Blood draw date/time:_____
Incubation end time_____ Signature:_____
Incubation at 37°C completed? YES NO

[ ] Syphilis IgG EIA
Syphilis specimen required information
[ ] Previous positive RPR
[ ] Previous positive IgG EIA
[ ] Previous positive FTA/TPPA

[ ] Varicella zoster virus
[ ] Virus identification
Virus suspected:_____
[ ] West Nile virus IgM (Human)

ADDITIONAL INFORMATION: MARK ALL THAT APPLY

[ ] Acute Serum (mm/dd/yyyy) _____/_____/_____
[ ] Convalescent Serum (mm/dd/yyyy) _____/_____/_____
[ ] Presumptive ID:_____
[ ] Disease suspected:_____
[ ] Employee medical screen
[ ] Other (specify):_____
[ ] Exposure
[ ] Work related
[ ] Pre-natal / Perinatal

COMMENTS: